STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155747	A. BUILDING 01 B. WING	09/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCREST NURSING CENTER	1300 MERCER AVE DECATUR, IN 46733

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/19/12 Facility Number: 000556 Provider Number: 155747 AIM Number: 100290130 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Woodcrest Nursing Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original section of the building consisting of A Wing, C Wing, the Extended Care Wing and the main dining room was surveyed with Chapter 19, Existing Health Care Occupancies.	K0000	Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law. Woodcrest Nursing Center maintains that the alleged deficiencies do not individually or collectively jeopardize the health and/or the safety of its residents nor are they of such character as to limit the provider's capacity to render adequate resident care. Furthermore, Woodcrest Nursing Center asserts that it is in substantial compliance with regulations governing the operation of long term care facilities, and this Plan of Correction in its entirety constitutes this provider's allegation of compliance and, thereby, we request resurvey to verify such as of October 19 th , 2012. **Further, we request desk review (paper compliance) for compliance, if acceptable.** Completion	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridors with hard wired smoke detectors in the resident rooms. The facility has a capacity of 143 and had a census of 123 at the time of this survey. The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage. All areas where the residents have customary access were sprinklered. Areas providing facility services were sprinklered Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/26/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:		dates are provided for procedural processing purposes to comply with federal and state regulations, and correlate with the most recent contemplated or accomplished corrective action. These do not necessarily chronologically correspond to the date that Woodcrest Nursing Center is under the opinion that it was in compliance with the requirements of participation or that corrective action was necessary.	

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K0018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 2 Activity/Therapy room corridor doors closed and latched into the door frame. This deficient practice could affect at most 4 residents in the Activity/Therapy room. Findings include: Based on observation with the Executive Director, Maintenance Lead, Maintenance Technician, Environmental Services Supervisor and the Environmental Services Trainee on 09/19/12 at 2:24 p.m., both of the double corridor doors entering the Activity/Therapy	K0018	**K018** It is the policy of this provider to provide positive latching devices as specificed in NFPA 101. *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:*The roller latch was replaced with a positive latching device on September 20th.*2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken:* Other residents with the propensity to be affected by the alleged deficient practice were identified as those in the activity room. None were so identified. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does*	09/20/2012

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	room did not have positive latching hardware. The right side door did latch into the frame but the left door required a key to deadbolt the door into the stationary right door. This was acknowledged by the Executive Director at the time of observation. 3.1-19(b)		*not recur:* The roller latch was replaced with a positive latching device on September 20th. The requirement is for a positive latching device - this action corrects the issue. Maintenance staff was in-serviced that roller latches cannot be used in the SNF are of the complex. 4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place: The replacement latch meets the regulation. No further action would be required. *5. Completion date:* September 20th, 2012.	

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K0038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress through 4 of 8 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice could affect 50 residents. Findings include: Based on observation with the	K0038	**K038** It is the policy of this provider to assure that exit access is arranged so that exits are readily available at all times. *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:* The existing magnetic locks were replaced by "smart locks" which allow the door to open after 15 seconds of pressure on the horizontal latching bar. It should be noted that when the pressure is placed on the bar, an alarm is activated. Signage was placed on the exit doors as required. *2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken:* Other residents with the propensity to be affected by the alleged deficient practice were identified as those who needed to use the emergency exits. None were so identified. The above correction allowed the doors to open as required by NFPA 101. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:* The existing magnetic locks were replaced by "smart locks" which allow the door to	10/01/2012

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	Executive Director, Maintenance Lead, Maintenance Technician # 1, Environmental Services Supervisor and the Environmental Services Trainee on 09/19/12 during the tour from 12:07 p.m. to 2:15 p.m., both exit doors from A wing and C wing required a key to unlock and open the emergency exit doors. Based on an interview with Maintenance Technician # 1 at the time of observation, maintenance staff, nursing staff and unit managers are the only staff with a key to these exit doors. This was confirmed by the Executive Director during a phone conversation on 09/21/12 at 3:15 p.m. 3.1-19(b)		open after 15 seconds of pressure on the horizontal latching bar. It should be noted that when the pressure is placed on the bar, an alarm is activated. Signage was placed on the exit doors as required.4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place: The replacement smart locks meet the requirement - no further action would be required. *5. Completion date:* October 1st, 2012.	

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K0044 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observations and interview, the facility failed to ensure 1 of 4 sets of fire barrier doors was provided with the appropriate fire protection rating for the location in which they are installed. LSC 7.2.4 leads to LSC 7.2.4.3.4 which requires openings in fire barriers comply with LSC 8.2.3.2.3.1 which requires 1 1/2 hour doors in 2 hour fire barriers. This deficient practice could affect 72 residents in the main dining room. Findings include: Based on an observation with the Executive Director, Maintenance Lead, Maintenance Technician # 1, Environmental Services Supervisor and Environmental Services Trainee on 09/19/12 at 2:55 p.m., there was a two hour fire separation wall between the Healthcare and Independent living. This wall contains a set of nonrated metal doors. Maintenance Technician # 1 confirmed the separation wall was	K0044	It is the policy of this provider to assure that fire rated doors meet the NFPA code requirements for fire barriers. *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:* We believe the doors meet the requirements but cannot locate the necessary documentation. A reputable contractor was contacted to correct the issue. A bid was obtained and accepted to remove and replace the doors and frame in question. The doors are on order and a copy of the contract is attached (addendum #1). *2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken:* Other residents with the propensity to be affected by the alleged deficient practice were identified as those using the dining room. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:* A reputable contractor was contacted to correct the issue. A bid was obtained and accepted to remove and replace the doors and frame in question. The doors are on order and a copy of the	10/19/2012

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	a two hour fire wall. 3.1-19(b)		contract is attached (addendum #1). *4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place:* The PI/QA&A Committee will review the summary from above and make recommendations based on the summaries for continued monitoring. *5. Completion date:* October 19 th , 2012.	

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K0061 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 1. Based on observation and interview, the facility failed to ensure 1 of 1 post indicator valves (PIV) was electronically supervised. This deficient practice affects all occupants. Findings include: Based on observation with the Executive Director, Maintenance Lead, Maintenance Technician # 1, Environmental Services Supervisor and the Environmental Services Trainee on 09/19/12 at 2:25 p.m., the PIV was padlocked in the open position. No electronic tamper device was observed on the PIV. This was confirmed by the Executive Director at the time of observation. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 2 water valves for the sprinkler system were electronically supervised. This	K0061	**K0061**It is the policy of this provider to maintain the control valves for the fire suppression system (sprinkler) in a supervised condition. *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:* On October 5th, electronic supervision was installed on the PIV and the 2 - 4" gate valves supplying water to the fire suppression system (sprinkler) for the facility. The chain locks were removed from the 2 - 4" gate valves. *2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken:* Other residents with the propensity to be affected by the alleged deficient practice were identified as all. The correction as written in section #1, corrects the issue for all. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:* On October 5th, electronic supervision was installed on the PIV and the 2 - 4" gate valves supplying water to the fire suppression system (sprinkler) for	10/05/2012

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	deficient practice affects all occupants. Findings include: Based on observation with the Executive Director, Maintenance Lead, Maintenance Technician # 1, Environmental Services Supervisor and the Environmental Services Trainee on 09/19/12 at 12:53 p.m., both water shut off valves in the sprinkler riser room were secured in the open position with a chain and a padlock, however, there was no electronic supervision of the valves. This was confirmed by the Executive Director at the time of observation. 3.1-19(b)		the facility. The chain locks were removed from the 2 - 4" gate valves. In addition, the supervision is tied into the fire detection system, and upon tampering, sets off an alarm. *4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place:* The correction resolves the issue and requires no further action. *5. Completion date:* October 5th, 2012.	

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K0144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate: 1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning. (b) Individual visual signals plus a common audible signal to warn of	K0144	**K0144** It is the policy of this provider to appropriately monitor the generator and its function. *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:* A monitoring station was installed at the nurses' station which is manned 24h/7d, as specified. *2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken:* Other residents with the propensity to be affected by the alleged deficient practice were identified as all. The corrective action described in section #1 resolves the issue for all. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:* A monitoring station was installed at the nurses' station which is manned 24h/7d, as specified. *4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place:* The installation and placement of the monitoring station corrects the issue. No futher action is required. *5.*	10/05/2012

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	an engine-generator alarm condition shall indicate: 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all occupants. Findings include: Based on an observation with the Executive Director, Maintenance Lead, Maintenance Technician # 1, Environmental Services Supervisor and the Environmental Services Trainee on 09/19/12 at 1:10 p.m., the emergency generator did have a remote annunciator panel		*Completion date:* October 5 th , 2012.	

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	located in the electrical room across from the main dining room. A trouble light for the generator annunciator panel was located on Elm Street in A wing. Neither location was continuously occupied by staff. This was confirmed by the Executive Director at the time of observation. 3-1.19(b)			

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K0147 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords such as an extension cord was not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect all occupants. Findings include: Based on an observation with the Executive Director, Maintenance Lead and Maintenance Technician # 1 on 09/19/12 at 12:55, a heavy duty extension cord was plugged in and providing power to the spare compressor in the sprinkler riser room. Based on interview with Maintenance Technician # 1 at the time of observation, the facility was not	K0147	**K0147** It is the policy of this provider to not use extension cords except as specified in the NFPA 101. *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:* The extension cord was removed from service in the presence of the surveyor on September 19th. *2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken:* Other residents with the propensity to be affected by the alleged deficient practice were identified as those using extension cords. None were so identified. The correction in section #1 resolves the issue for all. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:* The extension cord was removed from service in the presence of the surveyor on September 19th. 4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place: The monthly inspection conducted by the Environmental services	09/19/2012

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCREST NURSING CENTER	1300 MERCER AVE DECATUR, IN 46733

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	using the spare compressor at this time and removed the extension cord. 3.1-19(b)		department will be expended to include ancillary service areas (i.e. the mechanical rooms). This monthly inspection includes looking for extension cords in use in resident areas and immediately taking them out of service. The results of the inspections shall be communicated to the PI/QA&A committee by the Director of Environmental services, each month for 6 months. The PI/QA&A Committee will review the summary from above and make recommendations based on the summaries for continued monitoring. *5. Completion date:* September 19 th , 2012.	

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K0000	A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/19/12 Facility Number: 000556 Provider Number: 155747 AIM Number: 100290130 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Woodcrest Nursing Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The Rehabilitation Administration addition including a rehabilitation pool, apartment, nurses' station and offices was surveyed with Chapter 18, New Health Care Occupancies.	K0000	Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law. Woodcrest Nursing Center maintains that the alleged deficiencies do not individually or collectively jeopardize the health and/or the safety of its residents nor are they of such character as to limit the provider's capacity to render adequate resident care. Furthermore, Woodcrest Nursing Center asserts that it is in substantial compliance with regulations governing the operation of long term care facilities, and this Plan of Correction in its entirety constitutes this provider's allegation of compliance and, thereby, we request resurvey to verify such as of October 19 th , 2012. **Further, we request desk review (paper compliance) for compliance, if acceptable.** Completion	

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	This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridors with hard wired smoke detectors in the resident rooms. The facility has a capacity of 143 and had a census of 123 at the time of this survey. The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage. All areas where the residents have customary access were sprinklered. Areas providing facility services were sprinklered The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:		dates are provided for procedural processing purposes to comply with federal and state regulations, and correlate with the most recent contemplated or accomplished corrective action. These do not necessarily chronologically correspond to the date that Woodcrest Nursing Center is under the opinion that it was in compliance with the requirements of participation or that corrective action was necessary.	

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K0061 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 1. Based on observation and interview, the facility failed to ensure 1 of 1 post indicator valves (PIV) was electronically supervisor. This deficient practice affects all occupants. Findings include: Based on observation with the Executive Director, Maintenance Lead, Maintenance Technician # 1, Environmental Services Supervisor and the Environmental Services Trainee on 09/19/12 at 2:25 p.m., the PIV was padlocked in the open position. No electronic tamper device was observed on the PIV. This was confirmed by the Executive Director at the time of observation. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 2 water valves for the sprinkler system were electronically supervised. This	K0061	**K0061**It is the policy of this provider to maintain the control valves for the fire suppression system (sprinkler) in a supervised condition. *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:* On October 5th, electronic supervision was installed on the PIV and the 2 - 4" gate valves supplying water to the fire suppression system (sprinkler) for the facility. The chain locks were removed from the 2 - 4" gate valves. *2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken:* Other residents with the propensity to be affected by the alleged deficient practice were identified as all. The correction as written in section #1, corrects the issue for all. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:* On October 5th, electronic supervision was installed on the PIV and the 2 - 4" gate valves supplying water to the fire suppression system (sprinkler) for	10/05/2012

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	deficient practice affects all occupants. Findings include: Based on observation with the Executive Director, Maintenance Lead, Maintenance Technician # 1, Environmental Services Supervisor and the Environmental Services Trainee on 09/19/12 at 12:53 p.m., both water shut off valves in the sprinkler riser room were secured in the open position with a chain and a padlock, however, there was no electronic supervision of the valves. This was confirmed by the Executive Director at the time of observation. 3.1-19(b)		the facility. The chain locks were removed from the 2 - 4" gate valves. In addition, the supervision is tied into the fire detection system, and upon tampering, sets off an alarm. *4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place:* The correction resolves the issue and requires no further action. *5. Completion date:* October 5th, 2012.	

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K0143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 2 oxygen supply storage rooms was separated by construction with a one hour fire resistant rating. NFPA 99, 8-3.1.11.1 requires storage for nonflammable gases shall comply with 4-3.1.2. NFPA 99, 4-3.1.1.2(a) requires at least one hour fire resistant enclosures shall be provided for the storage of oxidizing agents such as oxygen. Furthermore, sprinklered hazardous areas such as the oxygen storage room are required to be equipped with self closing doors and the door is required to	K0143	**K0143** It is the policy of this provider to sprinklered, mechanically ventilated oxygen storage. *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:* The self closing mechanism on the door to the oxygen room lacked sufficient mechanical advantage to latch the door. The door closer was replaced with a stronger mechanical self closer, which now allows the door to close and to latch as required. *2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken:* Other residents with the propensity to be affected by the alleged deficient practice were	10/05/2012

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	latch. This deficient practice could affect 10 residents on the Extended Care wing. Findings include: Based on observation with the Executive Director, Maintenance Lead, Maintenance Technician # 1, Environmental Services Supervisor and the Environmental Services Trainee on 09/19/12 at 1:40 p.m., the door to the oxygen manifold room for the piped in oxygen on the Extended Care Wing did self close but failed to latch into the door frame. Based on an interview with the Maintenance Technician # 1 at the time of observation, this is a problem due to the required mechanical ventilation and negative air flow in the room. 3.1-19(b)		identified as those resideing on the ECU. The correction in section #1 resolves the issue for all. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:* The door closer was replaced with a stronger mechanical self closer, which now allows the door to close and to latch as required. *4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place:* Replacing the door closer meets the requirement. No further action is necessary *5. Completion date:* October 5 th , 2012.	

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K0144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate: 1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning. (b) Individual visual signals plus a common audible signal to warn of	K0144	**K0144** It is the policy of this provider to appropriately monitor the generator and its function. *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:* A monitoring station was installed at the nurses' station which is manned 24h/7d, as specified. *2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken:* Other residents with the propensity to be affected by the alleged deficient practice were identified as all. The corrective action described in section #1 resolves the issue for all. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:* A monitoring station was installed at the nurses' station which is manned 24h/7d, as specified. *4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place:* The installation and placement of the monitoring station corrects the issue. No futher action is required. *5.*	10/05/2012

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	an engine-generator alarm condition shall indicate: 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all occupants. Findings include: Based on an observation with the Executive Director, Maintenance Lead, Maintenance Technician #1, Environmental Services Supervisor and the Environmental Services Trainee on 09/19/12 at 1:10 p.m., the emergency generator did have a remote annunciator panel		*Completion date:* October 5 th , 2012.	

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	located in the electrical room across from the main dining room. A trouble light for the generator annunciator panel was located on Elm Street in A wing. Neither location was continuously occupied by staff. This was confirmed by the Executive Director at the time of observation. 3-1.19(b)			

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K0147 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords such as an extension cord was not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect all occupants. Findings include: Based on an observation with the Executive Director, Maintenance Lead and Maintenance Technician # 1 on 09/19/12 at 12:55, a heavy duty extension cord was plugged in a providing power to the spare compressor in the sprinkler riser room. Based on interview with Maintenance Technician # 1 at the time of observation, the facility was not	K0147	**K0147** It is the policy of this provider to not use extension cords except as specified in the NFPA 101. *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:* The extension cord was removed from service in the presence of the surveyor on September 19th. *2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken:* Other residents with the propensity to be affected by the alleged deficient practice were identified as those using extension cords. None were so identified. The correction in section #1 resolves the issue for all. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:* The extension cord was removed from service in the presence of the surveyor on September 19th. 4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place: The monthly inspection conducted by the Environmental services	09/19/2012

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	using the spare compressor at this time and removed the extension cord. 3.1-19(b)		department will be expended to include ancillary service areas (i.e. the mechanical rooms). This monthly inspection includes looking for extension cords in use in resident areas and immediately taking them out of service. The results of the inspections shall be communicated to the PI/QA&A committee by the Director of Environmental services, each month for 6 months. The PI/QA&A Committee will review the summary from above and make recommendations based on the summaries for continued monitoring. *5. Completion date:* September 19 th , 2012.	